BUSINESS PERSPECTIVES ON THE UNINSURED

June 13, 2001
The University of Chicago Gleacher Center
Chicago, Illinois

CONFERENCE REPORT

Sponsored by:
CHICAGO BUSINESS GROUP ON HEALTH
HEALTH AND MEDICINE POLICY RESEARCH GROUP
MIDWEST BUSINESS GROUP ON HEALTH

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HMPRG has a twenty-year history of evaluating local health policy as an independent, voluntary policy center with a mission centering on the health of the poor and underserved. Health and Medicine has been long familiar with the developments that have shaped the availability of health care to the poor in the region, and has maintained its influence by developing groundbreaking standards for public programs. Health and Medicine currently serves in two key capacities: to promote dialogue on health reform among diverse constituencies, and to interpret the needs of the state, city, and county for reconfigured health programs. Not only does Health and Medicine contribute to local policy development, but also provides national thinkers with the rationale for our local agendas.

MIDWEST BUSINESS GROUP ON HEALTH (MBGH)

Formed in February of 1980, MBGH is a coalition of employers working together to provide leadership and knowledge to continuously improve the quality and cost-effectiveness of health services. Members include public and private employers of all sizes in an eleven-state region.

MBGH can show any employer how to improve the management of its health programs for employees. Tools such as the *Dartmouth Atlas of Health Care* are available along with training to use them in finding health care quality problems that can be solved. Active participation as a member in regional committees/task forces and in local chapter committees and projects will put the employer on the leading edge of health program management. Members measure their results in improved employee satisfaction and reduced costs of health services.

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FOREWORD

This paper summarizes the proceedings of a conference, the first of its kind, *Business Perspectives on the Uninsured*, held June 13, 2001 to provide the Illinois Assembly with input from the state's business community. The conference was designed to serve as a forum for dialogue on the role of employers' in addressing the problem of the nation's uninsured and particularly the 1.8 million uninsured in Illinois. This meeting was an outgrowth of work that began at the Illinois Assembly on the Uninsured, an initiative of the Illinois Department of Insurance to recommend state solution for assisting residents without health insurance. Members of that group recognized the need to engage the business community early in addressing the growing number of uninsured. What follows is a summary of that meeting.

Three groups collaborated with the Illinois Department of Insurance in developing this conference. The Chicago Business Group on Health, the Health and Medicine Policy Research Group, and the Midwest Business Group on Health, worked together to convene health policy and business leaders to learn about strategies for covering the uninsured and to discuss the strengths, weaknesses, and feasibility of these different strategies from an employer perspective. Representatives of individual employers and Illinois' leading business organizations participated in the half-day meeting. Representing both small and large businesses, the attendees raised a multitude of viewpoints about this complex problem, including the stake of businesses, if any, in the reduction of the number of the uninsured.

The forum was broadly divided into three sections. The first part of the day provided education by health policy experts on the scope of the uninsured problem and options for change that are now being tried or under consideration on the local, state, and federal levels. Participants then divided into small discussion groups to try answering a series of provocative and difficult questions about the role of business in addressing the uninsured. This summary reveals considerable consensus on broad concerns, but relatively less on more specific questions and solutions.

Former United States Senator, Paul Simon served as the day's keynote speaker for the final portion of the day. As Chair of the Illinois Assembly, Senator Simon expressed his hope that the Assembly should set large goals and not shy away from substantial, comprehensive strategies in addressing the uninsured. He spoke of the issue in a political context and related the challenge of the uninsured to the larger problems of the American political system, particularly the need for campaign finance reform. He urged the participants to make Illinois a model for other states.

The goals of the day were pioneering; solving this problem will take enormous effort, challenging every sector of society. We hope that these proceedings serve as a useful launching pad for the development of programs and proposals to address the needs of the uninsured that make economic sense from a business perspective.

CONFERENCE AGENDA

8:15 am **REGISTRATION AND BREAKFAST**

8:30 am **INTRODUCTION AND WELCOME**
Larry Boress
Executive Director, Chicago Business Group on Health
Vice President, Midwest Business Group on Health
Jim Mortimer
President, Midwest Business Group on Health
Member, Illinois Assembly
Hank Webber
Vice President for Community and Government Affairs, University of Chicago
Board Member, Health and Medicine Policy Research Group

8:40 am **UNINSURED IN ILLINOIS: UPDATE FROM THE ILLINOIS ASSEMBLY**
Madelynne Brown
Assistant Director, Illinois Department of Insurance

8:55 am **WHY SHOULD BUSINESS CARE ABOUT THE UNINSURED?**
Raymond Werntz
President, Consumer Health Education Council
Board Member, Health and Medicine Policy Research Group

9:15 am **THE ECONOMY OF HEALTH CARE: A FORWARD LOOK AT POLICY OPTIONS**
M. Edith Rasell, M.D., Ph.D
Director, Economic Analysis and Research Network, Economic Policy Institute

9:35 am **PROMISES AND CHALLENGES OF EXPANDING PRIVATE HEALTH INSURANCE TO THE WORKING UNINSURED**
Lisa Duchon, Ph.D.
Deputy Director, Task Force on the Future of Health Insurance, Commonwealth Fund

9:50 am **PUBLIC SECTOR OPTIONS**
Quentin D. Young, M.D.
Past President, American Public Health Association
Chairman, Board of Directors, Health and Medicine Policy Research Group
Member, Illinois Assembly

10:05 am **INSTRUCTIONS FOR SMALL GROUPS**
Hank Webber

10:10 am BREAK

CONFERENCE AGENDA

10:20 am **SMALL GROUP DISCUSSIONS**

11:20 am **SMALL GROUP PRESENTATIONS**
Hank Webber, Facilitator

12:15 pm Lunch

12:45 pm ***KEYNOTE ADDRESS:*** **THE CIVIC CHALLENGE OF THE UNINSURED**
Paul Simon
Former U.S. Senator
Professor, Public Policy Institute, Southern Illinois University
Co-chair, Illinois Assembly

1:45 pm **ADJOURN**

SPEAKERS

MADELYNNE BROWN
Deputy Director
Illinois Department of Insurance

LISA DUCHON, Ph.D.
Assistant Director
Task Force on the Future of Health
The Commonwealth Fund

M. EDITH RASELL, M.D., Ph.D.
Director
Economic Analysis and Research Network
Economic Policy Institute

PAUL SIMON
Former United States Senator
Professor
Pubic Policy Institute
Southern Illinois University
Co-chair, Illinois Assembly

HENRY WEBBER
Vice-President for Community and
Government Affairs
The University of Chicago

RAYMOND WERNTZ
President
Consumer Health Education Council

QUENTIN YOUNG, M.D.
Past President
American Public Health Association
Chairman
Health and Medicine Policy Research Group
Member
Illinois Assembly

EXECUTIVE SUMMARY

Introductory remarks by Larry Boress, Jim Mortimer, and Hank Webber challenged the conference participants to address: 1) Why is the problem of uninsurance a problem for businesses? 2) What can business leaders recommend to the Illinois Assembly as it develops strategies for addressing the uninsured? 3) What policy proposals can business leaders agree would reduce the problem and receive wide support from public and private sectors?

Following welcoming remarks, a panel of distinguished speakers made presentations designed to educate and stimulate discussion among the audience of business leaders. The first presenter was Madelynne Brown, Deputy Director of the Department of Insurance. Ms. Brown described the $1.2 million grant awarded to Illinois by the Health Resources and Services Administration to research and develop a State plan to reduce the number of uninsured in Illinois. The three major components of the plan are: 1) a statewide telephone survey conducted by the University of Illinois, Chicago; 2) thirty-five focus groups with large and small business employers and individuals to gather qualitative input; and 3) the Illinois Assembly, a committee of over 100 members, including providers, public health agencies, business leaders, consumers, and legislators to review research findings and develop a statewide plan.

Raymond Werntz, President of the Consumer Health Education Council spoke on the advantages and incentives for employers to become actively involved in expanding employer-sponsored coverage, particularly on a community level. He advocated for coverage for all employees, employer education on the value of group purchasing, and greater employer awareness of federal, state, and local initiatives that make coverage more affordable for small employers and individuals.

Dr. Edie Rasell, the Director of the Economic Analysis and Research Network at the Economic Policy Institute, outlined the recent past and the future of health care spending and coverage in the United States. Currently, the U.S. spends about 13.6% of the GDP on healthcare. Because of the aging population and characteristics of the health care industry, costs are expected to rise. She described several current proposals to incrementally increase coverage of the uninsured, including employer mandates, expansion of public programs, and tax credits. Although each option has strengths and challenges, Dr. Rasell explained why a single-payer, universal system would lower health care costs by 10% by decreasing the high administrative costs of the current system.

Dr. Lisa Duchon of The Commonwealth Fund presented several private, employer-based options for expanding coverage to the working uninsured. She described the diversity of the uninsured population in the United States and noted particularly that 80% of the uninsured are working. She discussed important principles and trade-offs in expanding coverage such as adverse selection, take-up, administrative efficiency, horizontal equity, and stability.

Dr. Quentin Young briefly highlighted key organizations and successes of the United States' public health and medicine system. He cited the Medicare and Medicaid programs, the National Institutes of Health, Centers for Disease Control and Prevention, the Military, and public hospitals such as Cook County. He recommended that the United States should build on this infrastructure by working towards a universal, single-payer system.

The conference participants broke into discussion groups to consider questions about the role of employers in addressing the uninsured. The groups identified possible strategies for expanding coverage, but reached consensus only on broad principles, including:

- Recognition that the problem of the uninsured affects businesses.
- There should not be employer mandates.
- Employees should take more responsibility for their own health coverage.
- Experimentation at state and local levels are strongly preferred over federally-based solutions.
- As employer-sponsored insurance becomes the cornerstone of health coverage, more employer involvement in policy development is necessary.
- Better data is needed to educate employers and policy makers on the relative strengths of options for coverage expansion.
- Because public programs cover high-cost communities, a mixed system of public and private coverage is favored to keep private costs low.

As the keynote speaker, Former Senator Paul Simon addressed the political realities that shape the framework in which we discuss the uninsured. This includes the power of a story, or putting a human face on a monumental problem, such as the uninsured. He emphasized the need for campaign finance reform to effectuate better use of politicians' energies. He called for a comprehensive statewide plan for attacking the problem of the uninsured, with strong leadership by the Illinois Assembly.

INTRODUCTION AND WELCOME

Larry Boress, Executive Director, Chicago Business Group on Health

Mr. Boress opened the conference and recognized the event's co-sponsors. He described that the goal of this meeting was to encourage the business community to take a pro-active stance to the uninsured issue. Illinois has received a federal grant to study the uninsured and as they develop their program, it is important for business leaders around the State to begin discussing this program and provide their insights to the state process.

Jim Mortimer, President, Midwest Business Group on Health

Mr. Mortimer stated that it was pleasure for the groups to work together with the Department of Insurance. He commented that this is an important issue - the uninsured - for Illinois and for the business community. This meeting comes at a time when the issue of the uninsured is going to become one of the State's top priorities. He encouraged the participants to examine what business leaders should be doing to assist in preparing for productive discussions in Springfield and its impact on the business community.

Hank Webber, Vice President for Community and Government Affairs, University of Chicago

Mr. Webber served as the facilitator for the conference. He told the participants that the most important part of the day would be the small group discussions. The goal of the morning presentations was not just education. The goal was to encourage business leaders to think about a set of policy proposals for helping reduce the problem of the uninsured that could receive wide support from both public and private – and in particular private – sector interests.

PRESENTATION BY
MADELYNNE BROWN, DEPUTY DIRECTOR, IL DEPARTMENT OF INSURANCE
"Uninsured in Illinois: Update from the Illinois Assembly"

Ms. Brown's presentation focused on the Planning Block Grant given to Illinois by the Health Resources and Services Administration, which is being used to research and develop health insurance options for Illinois' 1.8 million uninsured.

Introduction
Between 12-14% of Illinois residents are uninsured. In the discussion about the uninsured, it is key to recognize that the majority of the uninsured are employed. Information from the Department of Public Health shows that the disparities of health status between the insured and uninsured have a great deal to do with the productivity of uninsured workers.

Grant details
Illinois recognized the need for a closer look at the problem of the uninsured in the state. The United States Department of Health and Human Services awarded $20 million in State grants through the Health Resources and Services Administration to study the issues. Illinois was one of the first of 20 states to receive a grant. Illinois' grant was for $1.2 million.

Program Goals
The goals of the program were to collect state-specific data on the uninsured population in Illinois, develop a proposal for the State Administration and Legislature to provide insurance to the uninsured, and to submit a summary report to the Secretary of Health and Human Services. The Illinois proposal will be combined with other states' proposals in a larger, comprehensive report to Congress.

Project Governance
The project is to be led by the Illinois Department of Insurance, coordinated by a Steering Committee. The Steering Committee is composed of the Office of the Governor; IL Department of Insurance; SIU-Carbondale; Department of Public Aid; Department of Commerce and Community Affairs; Department of Human Services; and the Illinois Comprehensive Health Insurance Plan.

Research on the Uninsured
The project is collecting data on the characteristics of the uninsured through four activities:

- A statewide telephone survey conducted by University of Illinois, Chicago on their insurance status.
- Expansion of the Behavioral Risk Factor Surveillance System by the Illinois Department of Public Health.
- Qualitative information gathered through 35 focus groups of large and small business employers, individuals, conducted by SIU to gather input about insurance coverage.
- Analysis of census data and other health data to determine national trends in uninsurance by the Illinois Department of Public Health and University of Illinois, Chicago

Possible Strategies for Expanding Access

Strategies were identified by looking at survey programs in other states, identifying programs to increase health insurance coverage, and expanding public programs and support for private programs.

Consensus Development

In order to put plans into action and develop consensus about approaches to be taken, the State wanted to involve all the individuals and organizations that play a role in providing insurance. Therefore, the State created the "Illinois Assembly" of providers, public health agencies, consumers, insurers, and legislators. The Assembly began with an introductory meeting on January 11, 2001. Shortly thereafter, a web site and reading list were created. A meeting of the Illinois Assembly will be held on July 10, 11, 12 for a preliminary overview of research findings and the development of recommendations. After the research presentation, the Assembly will break into small groups to address targeted questions. The results and a final plan review will be conducted on September 10, 2001.

PRESENTATION BY
RAYMOND WERNTZ, PRESIDENT, CONSUMER HEALTH EDUCATION COUNCIL
"Attacking the Problem By Thinking Differently"

Mr. Werntz's presentation developed the argument for employer involvement in designing solutions to the problem of the uninsured.

Introduction
The most active parties in Washington working on solutions to the rising numbers of the uninsured don't include employers, and some influential health policy experts treat employment-based coverage as part of the problem, not part of the solution. However, there are many reasons to consider an employer-championed solution.

1. ***Employers have a lot to lose if they choose to leave the problem to other groups and to the government. There are good business reasons for attacking the problem rather than ignoring or withdrawing from it.***

    - ❖ Many of the policy proposals circulating around Washington could dramatically alter the landscape of America's health care system and the influence of employers.

    - ❖ Before employers can decide on an appropriate course of action, they need to consider attacking the root causes. This may actually not only expand coverage but improve affordability and quality.

2. ***A few definitions and fundamentals important to the discussion of why employers may have a lot to lose if they choose to be led rather than be leaders:***

    - ❖ "Sponsor": A sponsor is a person or other entity that pays most of the costs of someone's care and has the power to influence the system. Employers and the government are sponsors; individuals can be sponsors as well.

    - ❖ The nature of coverage today. Roughly thirty years ago, it was only money that was paid after an employee received medical care. Today, coverage is much more. It is the key to a regular source of care and sets the rules of engagement for doctors and their patients. In the hands of sophisticated sponsors, it can help organize and manage entire care systems.

    - ❖ Research consistently documents that employees value health care coverage more than any other benefit. There is also ample evidence that employers know this and acknowledge the recruitment, retention and productivity advantages health coverage offers them. Employees also continue wanting employers to make coverage arrangements for them in spite of their reported unhappiness with managed care.

    - ❖ Over the past 20 years, employers have changed the nature of health care by:

- Facing up to the challenge of cost benefit tradeoffs that must be considered in allocating care resources across large populations.

- Working with providers on matters of process efficiency, quality and most recently, patient safety.

- Supplementing coverage with educational and care management programs.

- Integrating health care with disability and other programs to improve outcomes and return to work.

3. Why is employer dominance of health care in jeopardy?

- ❖ Incongruity and magnitude of the problem. America spends more per person on health care than any other country, yet it is ranked only average on the health of its citizens.

- ❖ About 85% of the uninsured are workers and their families. A policy solution to increase public and/or private individual coverage may intentionally or unintentionally decouple coverage from employment.

- ❖ There is significant tension between private and public coverage that results in much of the criticism leveled against employer-sponsored care. Employer-sponsored coverage is voluntary and driven by business necessity, whereas public coverage secures access for those who need it.

4. Why is private coverage expansion not a high priority option among policy makers? It's perceived as "unreliable".

- ❖ For most employers, health care premiums are a cost of doing business. Covering more people is an expensive proposition.

- ❖ Employers spend money on employees if it leads to profitability. The recent flirtations with near full employment actually produced an uptake in coverage last year among smaller employers. This may evaporate if competition for employees abates as the economy slows down.

- ❖ From one perspective, the problems of small businesses – mainly access to good, affordable coverage – seem different from those of larger ones – cost inflation and quality. In reality, the consequences of the division between large and small employers on solutions to the uninsured may lead to onerous results for both.

- ❖ Most uninsured workers lacking coverage are so situated because their employers do not offer it or because it is too expensive to take up. Very few don't enroll because they don't value coverage – but overwhelmingly it is a matter of cost.

- ❖ By using escalating premium costs as the main measure of coverage value, the prospects for fewer offerings and take-up loom as the economy slows down. Unless there are undiscovered means for attacking the drivers of inflation and redefining the value of coverage and the health it produces, increasing numbers of uninsured workers could dramatically change the role of employers in health care.

5. ***What can employers do to help alleviate the problem of the uninsured?***

- ❖ If coverage is offered, make sure all employees and their families have coverage, either through the employee's plan, a spouse's plan or a government plan if it is available to lower paid employees.

- ❖ Be alert to local, state and even federal initiatives that make coverage more affordable for small employers and individuals that don't have the option of employer or government sponsorship.

- ❖ Be concerned enough about the value of group purchasing to the business industry to be willing to surrender some individuality to common and enforceable standards for providers and plans in the community.

- ❖ Become familiar with the "Land Behind the Plan" and different perspectives on the "Business Case" for coverage expansion. Refer to attached chart on page 16.

6. A Better Business Case for providing and subsidizing coverage includes potential financial benefits of coverage expansion.

- ❖ Lower costs of care prices and use of care, as well as lower employee costs attributable to impaired health: absenteeism, materials' waste, turnover, etc.

- ❖ Improved revenues
  - Employee capabilities
  - Employee performance

7. Examples of employers working in communities to find new ways to lower the cost of coverage:

- ❖ ***Access Health of Muskegon, Michigan***
  Employers and providers joined forces to provide a health coverage product – not insurance that fills the gaps between commercial insurance and no insurance. Creative design and community subsidy.

- ❖ ***Metrolina of Charlotte, North Carolina***
  Large employers teaching small employers how to manage worker health to stabilize costs, beginning with a community wide analysis.

- ***Health Pass of New York City***
  Organized to provide a wide variety of low cost plans to small employers, giving them benefits usually reserved only to larger employers.

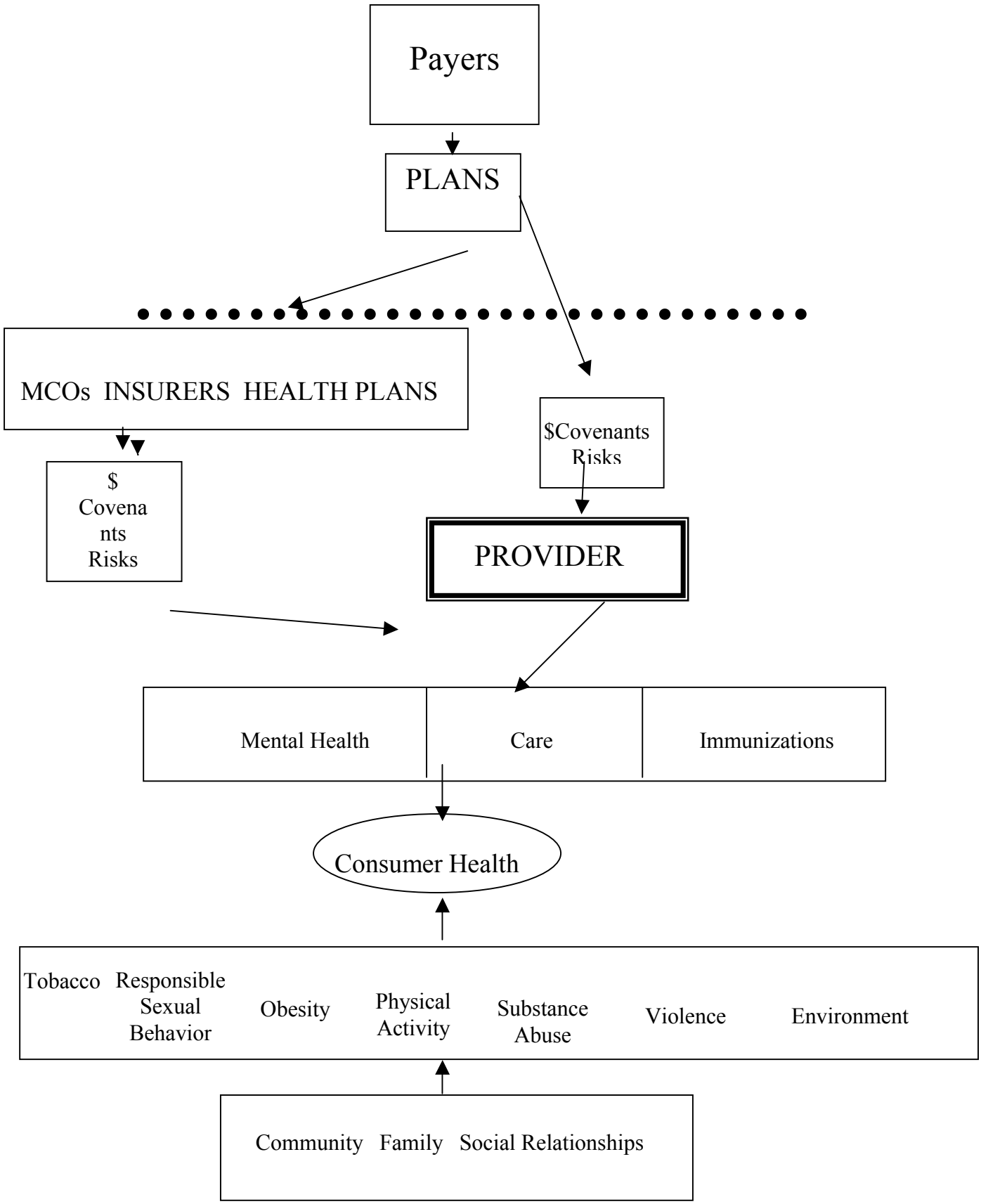
- ***Regional Health Forum of Atlanta, Georgia***
  Brings together stakeholders in community health to improve access, reduce disparities, and promote economic vitality.

8. We need to change our framework:

FROM. . .America cannot afford to provide coverage to all Americans

TO…America cannot afford NOT to provide coverage to all Americans.

THE "LAND" BEYOND THE PLAN



PRESENTATION BY

M. EDITH RASELL, M.D., PH.D., DIRECTOR, ECONOMIC ANALYSIS AND RESEARCH NETWORK, ECONOMIC POLICY INSTITUTE

"The Economy of Health Care: A Forward Look at Policy Options"

Dr. Rasell's presentation considered the United States' spending and health care costs, and future options of the private and public sectors regarding the expansion of health care coverage to the uninsured.

Introduction

- This year, the United States is spending roughly $1.4 trillion on health care, or 13.4% of GDP. The health outcomes and health status of the United States do not reflect the enormous amount of money put into the health industry.

- Fifty-five percent of $1.4 trillion is private money and 40% of all healthcare dollars are spent by employers. Even now, in excellent economic times, there are 42 million uninsured Americans, and many who are underinsured.

Recent History

- In 1993-94, the rate of increase in health care costs slowed down, largely due to the influence of HMOs and managed care and due to restrictions on Medicare expenditures. The health care share of the GDP stabilized.

- Because there will not be another shift into managed care, this cost decrease was a one-time event. Therefore, we have experienced all of the savings possible.

- The dominance of managed care combined with the recent consolidation among managed care plans results in lower bargaining- power for employers. At the same time, hospitals have also become more consolidated, partially offsetting the greater bargaining power of the managed care companies.

The Future

- According to the Health Care Financing Administration, in 2010 the United States will spend 16% of GDP on healthcare. The amount spent per person will rise by 50%. There are two fundamental reasons:
  - The United States population is aging, resulting in significantly increased health care spending.
  - Even though there are productivity gains among the general workforce, the nature of the healthcare industry, a people-intensive industry, makes such gains harder to achieve. Doctors take almost as much time today when seeing patients as in the past. However, the health industry wants the wage increases experienced by all other industries. This leads to price increases.

Comment
An audience member questioned the concept of zero productivity gains in medicine and the health care industry. For example, patients may administer their own medicine, or doctors may send patients out for tests that in the past were done by the doctors. Dr. Rasell responded by stating that new technologies and qualitative improvements actually create more time demand, because doctors must follow up on all the tests. She stressed that she was not asserting that there are NO productivity gains in the health care industry, but that they are much slower than in other markets.

Thinking About Cost

- Two important questions to ask:
  - What is the total cost of the system?
  - Who is paying those costs?

- The healthcare market is less effective in restricting prices rises than many other markets due to:
  - Inelastic demand: even if prices go up, people will still seek care.
  - Inadequate competition
  - Excess capacity

- Prices in the US are higher than in many other countries, particularly very high administrative costs: 25% of every healthcare dollar does not buy health care, but covers the administration. In other countries, this figure is closer to 15%.

Covering Everybody

- It would cost roughly $100 billion additional dollars to cover everyone.

- Of the $100 billion needed, roughly $50 billion is already in the system in the form of internal "cost shifting." Therefore, we need about $50 billion to cover the uninsured.

Options for Covering the Uninsured:
If people knowingly have coverage and use it, if average fees are paid to providers who therefore are willing to see people because they are giving adequate payment, if administrative expense of covering additional people is not astronomical, and because no special efficiencies are embedded, the first three options below cost nearly the same: $100 billion, of which $50 billion is new money.

1. Employer mandate

Strengths:

Most of the uninsured population work
No cost-shifting so employers who provide insurance would see costs fall
Levels the playing field between employers
Builds on familiar systems

Challenges:

Political opposition
Doesn't address the unemployed
Need for establishing a benefit standard
Some people can not afford the employee contribution

2. Expand public programs

Strengths:

Costs for employers would drop

Challenges:

Political opposition
Stigma, if viewed as a welfare program
Cumbersome, fragmented system
Chronically underfunded due to lack of political support

3. Tax credits

Strengths:

Gives low income population money to buy individual, private insurance
Insurance money derived from a mix of taxes and out-of-pocket

Challenges:

Private premium costs are roughly 40% higher because of greater administrative costs.
Some populations would still not be able to afford out-of-pocket costs.
Healthier people would have lower premiums.

These first three options just add more money to the current system, but do not address the current problems of high prices and high administrative costs.

4. Universal System

Strengths:

Could be modeled after Medicare, which is more effective than the private market in cost containment.
One system would address the current problems and allow more rational planning, impose a budget, less excess capacity, decrease in administrative overhead.
Many experts have stated that this type of system would decrease costs by 10%.

Challenges:

Current flaws of Medicare must be avoided
Political opposition

In Conclusion

Although the United States spends more than any other country on healthcare, the health outcomes are not of high quality. As a country, we should look beyond putting more money into a flawed system. From an economic standpoint, money spent on healthcare means less funding for other industries and programs.

PRESENTATION BY

LISA DUCHON, PH.D., DEPUTY DIRECTOR, TASK FORCE ON THE FUTURE OF HEALTH, THE COMMONWEALTH FUND

"Promises and Challenges of Expanding Private Health Insurance to the Working Uninsured"

Dr. Duchon's presentation focuses on private, employer-based options for expanding coverage to the working uninsured.

Diversity of Working Uninsured

The vast majority of uninsured--nearly 8 of 10--work or are part of a working family. Only fifteen percent of the uninsured were offered healthcare but refused coverage. Cost was the main reason. The uninsured population is a diverse group by age, health status and employment situation.

Age:	19-24: 24%	24-44: 51%	45-64: 25%	
Health:	Poor, fair or good: 37%	Very Good: 32%	Excellent: 31%	
# of employees:	Self: 10%	<25: 33%	25-499: 26%	>500: 31%

1999 Current Population Survey estimates by Sherry Glied, Columbia University, for The Commonwealth Fund.

The Problem of Adverse Selection:

"Adverse selection" is the tendency of those with higher-than-average health risks to apply for or maintain insurance coverage. In response to adverse selection, the insurer typically increases premium rates to cover increased medical costs, which can lead healthier individuals to drop out of the health plan or pool, leaving an ever smaller, sicker more expensive group to cover. Insurance companies often view small firms and small firm purchasing pools as being high risk for adverse selection, and thus often are reluctant to participate in coverage expansion initiatives targeting small firms.

A Shifting Population

It is important to note that from one year to the next, the face of the uninsured changes, about 28% of the uninsured are without coverage for 6 months and about 40% are without coverage for 18 months or longer.

What are some ways in which we can make employer-based coverage more affordable and stable for the working uninsured and their families regardless of their health status?

Guiding principles and trade-offs for assessing options to expand coverage

Will the Initiative:

- ❖ Achieve a net increase in the number covered? Trade-off: How do you minimize the number dropping adequate unsubsidized coverage for new subsidized coverage ("crowd out"), but also provide more stable coverage to those shifting on and off coverage and reduce the number of *under*-insured?

- ❖ Have high participation of the population eligible?. Trade-off: Is there adequate funding to support high enrollment? Is the initiative designed to attract a mix of individuals with high and low health risks?

- ❖ Be administratively simple from an employer or employee perspective? Trade-off: The eligibility rules need to be sophisticated enough to mitigate against people only enrolling when they are sick and leaving when they are not.

- ❖ Be cost-efficient in terms of the actuarial value of coverage for the premium price? Is benefit package a good value relative to premiums? Trade-off: Need benefits and pricing to attract health plans and providers to participate.

- ❖ Have horizontal equity—treat people or firms similarly in similar financial situations? E.g. of *in*equity: only allowing small, low wage firms not offering coverage to get a subsidy, thus penalizing similar firms who already offer coverage without a subsidy. Trade-off: Equity is more expensive.

- ❖ Have a stable source of financing and be a good use of scarce resources, short-term, long-term? Is sustainability built into the initiative? Trade-off: Sources of permanent financing may not be politically feasible to obtain.

Promising Models

- ❖ ***Massachusetts: Family Assistance Program***
  Offers generous subsides for small firms and subsidies for low wage workers. Financed by Medicaid waivers, S-CHIP, and state funds.

- ❖ ***Wisconsin: Alliance-Chamber Health Insurance Plan***
  A totally private model, provides access to health insurance for small firm members (<100) of local Chamber of Commerce. One health plan participates, and firms must use it exclusively.

- ***Arizona: Health Care Group of Arizona Reinsurance Program (ACHIP)***
  Prepaid group coverage through 3 HMOs for small firms (<50), self-employed; targets "micro" firms, part-time workers. State-financed reinsurance program for plans' high cost claims, funded with $8 million/yr in tobacco settlement funds.

Effect of Reinsurance on Premiums

- Government can play a role in addressing adverse selection and stabilizing private coverage initiatives for small employers by subsidizing the highest cost claims paid by participating insurers. This can reduce premium prices and thus attract healthier workers to the risk pool, and make it financially viable for health plans to offer coverage to the small groups that insurers often try to avoid.

- Actuarial research shows that by removing or reinsuring:
  - The 1% of highest cost cases, the premiums may decrease by 14%.
  - The 5% of highest cost cases, the premiums may decrease by 36%.

Conclusion – Lessons from Research:

- Small subsidies produce small take-up/participation rates.
- Programs to promote employer-sponsored insurance need strategic marketing.
- Employer-based programs must have adequate and stable funding sources.
- Purchasing cooperatives have helped expand choice but not coverage.
- Spreading the risk is critical to avoiding a "death spiral," from adverse selection.
- A voluntary program targeting a portion of uninsured must be part of a broader, comprehensive approach.
- Job-based coverage may not be the answer for everyone in the lower-income population, especially those in small firms.
  - *What mix of job-based coverage, Medicaid, CHIP, and safety-net provider support makes sense?*

PRESENTATION BY
QUENTIN YOUNG, M.D., CHAIRMAN, HEALTH AND MEDICINE POLICY RESEARCH GROUP
"Recognizing Public Health Successes"

Dr. Young's presentation highlighted the important role of the public health system in maintaining and improving the health of all the residents of the United States.

Two recommended readings:

- Marcia Angell, *Statement to the Congressional Black Caucus and the Congressional Progressive Caucus May 1, 2001.* This article is Dr. Angell's testimony to a Congressional panel, advocating a national health program and highlighting the inefficiencies of our current system.

- Uwe Reinhart, *Why are There So Many Uninsured? Is the Problem Permanent?* Dr. Reinhardt poses the problems of the uninsured by examining the efforts by the insured to expand coverage, and why past attempts to reduce the uninsured population have failed.

Successes of Public Health and Public Medicine in the United States
As a society, we undervalue the public health and public medical systems. In developing countries, the public health system is THE health system. The following is a brief look at the bedrocks of the United States' public health and public medical systems, which are very important and influential to the national healthcare system, and serve as models as we explore ways to expand health insurance.

- ***Medicare***
  - A national insurance program for adults over 65 years old.

- ***Medicaid***
  - Insurance program for the poor and disempowered populations.

- ***National Institutes of Health***
  - Serves as the major health research organization in the U.S.

- ***Centers for Disease Control and Prevention***
  - Ensures America's safety everyday.
  - Forms the backbone of the public health standards that are followed by local public health departments, many of which are underfunded, across the U.S.

- ***Military Medicine***
  - An organized, centralized care provider to the nation's armed forces.

❖ ***Public Hospitals***

- Care for those ill people that nobody else will take care of, at a lower cost and better outcomes than the private sector.
- There is a new Cook County Hospital, in part because of the efforts of the business community.
- Thirty community clinics in Cook County.

❖ In the last century, the life expectancy in the United States has doubled. Roughly 85% of this increase is due to public health successes.

❖ With global changes and technology, our public health protections are necessary and vital.

SMALL GROUP DISCUSSIONS

Conference participants were instructed to convene in groups of 7-10 members, with a designated facilitator of each group. The groups were to read and discuss six questions designed by the conference sponsors about the uninsured, employer involvement, and expanding health care coverage. The groups discussed and presented their suggestions in response to the following questions:

1. Based on what you have heard today, do you believe all Americans should have health care coverage?
    - If so, who should be responsible for paying for this insurance, employers, government, individuals, or a combination?

2. Do you think it is the employer's responsibility to see to it that all of their employees and their families have health insurance?
    - Do you think that employers should handle the administration of health insurance benefits for their employees? For their employee's dependents?
    - Do you think that employers should pay for health insurance for **all** of their employees? For their employee's dependents – to what extent?
    - Do you think employers should be out of the business of providing health insurance to employees and their dependents? If so, who should do this?

3. Do you think that there is a role for employers to play in expanding health insurance coverage to working uninsured people? Non-working uninsured?

4. What are some ways you think employers should encourage or require their employees to take up health insurance for them and their families?

5. Beyond coverage for your own employees, what would you support politically to expand coverage to the working uninsured?

6. If covering the uninsured is not now a priority for employers, what would it take to make it one? How would you and your colleagues be willing to assist the Illinois Assembly in its plans for the State's uninsured?

The groups reported a number of recommendations, concerns, and experimental ideas in response to the discussion questions. There was consensus on broad ideas and less agreement on specific strategies.

Areas of Consensus

Concern, but not uniform belief that the problem of the uninsured is a critical problem for businesses. Employers recognized that the uninsured is a problem that affects them because the vast majority of uninsured are employed, health insurance is consistently reported as one of the most valued benefits, and because the expenses of the uninsured are shifted in various ways to employers and employees. Employers did not agree on what involvement they should have in solving the problems.

No employer mandates – Employers feel that the government has already imposed too many regulations on employers. They claim the mandates increase employer costs, making insured products unaffordable to many small employers. They oppose more Federal or State mandates on coverage expansion or minimum benefit levels.

At the same time, as employer-sponsored insurance has become a predominant form of insurance coverage in the United States and 80% of the uninsured work, it would seemingly make sense to try to establish standards that all employers would follow. This would also help level the playing field between employers, but would be a very challenging undertaking.

Experimentation at State and Local levels —Employers resist Federally-based solutions. They support experimentation at the State and community levels. This was controversial from the speakers' point of view. For example, Dr. Rasell described how most of the savings of covering all people would only come from the significantly lower administrative costs of a single-payer program.

More employee responsibility – Employers believe that employees should take a more active role in their health insurance coverage. Employees should be made more price sensitive and take more personal responsibility for maintaining their health. Employers believe that the market will respond appropriately if people are in charge of their own care and costs.

This concept resonated throughout many of the proposed solutions; however, Dr. Rasell detailed many reasons as to why market-driven solutions have not been successful in health care – asymmetry of information, inadequate competition, and inelastic demand. Many analysts also question whether health coverage should be used to punish people for their personal choices or their illnesses.

More employer involvement in policy development – Employers recognized the need to be active participants in health care policy arenas, as employer-sponsored insurance has become a cornerstone of health coverage and employee benefits packages.

Better data – Better data would also allow for more educated comparisons of the different expansions and would strengthen the case for a sound policy decisions.

Mixed system of public and private coverage – Employers believe they are offering a valuable benefit to their employees, but view insurance expansion as a bottom-line budget concern. Therefore, they seem comfortable with the current situation of a mixture of public and private coverage, with the government taking responsibility for covering certain "high cost" populations. In general, though, employers are very skeptical of government programs and the government as payer because they fear that government funds will run out and employers will be left with the responsibility.

On the other hand, the Medicare program as a model of successful government health coverage receives high marks from most policy analysts.

Additional ideas were raised by the discussion groups that did not have consensus among all participants:

1. Interest in experimentation, but not about the biggest issues.
   Possibilities:
   - Public reinsurance pools to combat adverse selection in small employer pools – these pools would place enrollees with the greatest costs into a separate pool to help lower premiums. This has great potential for discrimination and tiered medicine.
   - Tax credits to employers – This would serve as a financial incentive for employers to cover all employees, but it would not alleviate many of the inherent problems that employers face such as higher premiums due to higher administrative costs. The credits would need to be very large in order to make insurance affordable to small employers, because the credits often come with the requirement that employers cover premiums at a minimum threshold.
   - Expand public programs for the unemployed uninsured – This proposal would expand the number of people covered by public programs, lowering costs for employers. The public system, aside from Medicare, though, is chronically underfunded because of lack of political support and suffers from stigma as a "welfare program."
   - Strengthen purchasing group models – Purchasing groups would allow different small employers to join together as a group in purchasing health insurance. These models are being tried in various communities, but with limited success. While this gives the employers bargaining power, it does not guarantee that the group would be able to insurance. It also does not make provision for portability.
   - Default plans, where companies fund a minimal package for those who don't choose to take up coverage from the plans offered – This would help guarantee coverage for all employees, but could also result in tiered medicine. It would also be a considerable challenge to have employers and health experts agree on minimum standards.

- Medical Savings Accounts (MSAs) – This is a market-based concept in which employees would be given a lump sum of money to spend on their health care. Responsibility would be shifted away from employers and to employees, making them more price sensitive. Many, especially low-income workers, though, may not seek necessary and preventive care in order to keep the money for other necessities. Avoiding primary and preventive services may ultimately increase health expenditures.

2. Education of both employees and employers regarding value, and educating employers about what they have at stake if there are uninsured workers in other companies. This requires additional resources and investment by both employers and employees and many still question whether that is the role of the workplace.

3. State tobacco settlement awards should be tapped for expanding insurance. All of the States received a portion of the 1997 Master Settlement Agreement against the largest tobacco companies. Generally, there is great competition for allocation of these funds and many opponents to this idea argue that the funds should be used for tobacco cessation and prevention efforts.

PRESENTATION BY
PAUL SIMON, FORMER SENATOR,
PROFESSOR, PUBLIC POLICY INSTITUTE, SOUTHERN ILLINOIS UNIVERSITY
"The Civic Challenge of the Uninsured"

Mr. Simon's keynote address focused on the realities of the political system, highlighting barriers to expanding health care coverage, but also advocating strong, comprehensive positions he hopes will come out of the Illinois Assembly.

Former Senator Simon began by stating that, in the efforts to expand health care coverage to the uninsured, employers have three options. They can:

- Retreat
- Muddle along
- Attack the problem, starting with the Illinois Assembly.

Former Senator Simon brought to the conference the political realities of our system. He believes that campaign finance reform is a necessity if we will ever see the desperately needed changes in health care and health care coverage. The current political structure makes politicians too vulnerable to special interests and the necessity of constant campaign fundraising. States should champion finding comprehensive solutions to the problem of the uninsured and the underinsured. Looking to the past, Illinois was the first state to enact mandatory school attendance. Although other states thought it a radical move, they soon followed Illinois' lead and enacted similar legislation. The same may happen with regard to insurance expansion for the large number of the uninsured, if Illinois attacks the problem and develops a comprehensive approach. Although he expressed his commitment to comprehensive change, he regretfully reported that his experiences in politics illustrate that change will likely happen incrementally.

Former Senator Simon sees the realities everyday of the uninsured. Citizens call him at home to explain their need for coverage, asking him for money to cover their basic medical necessities. He has listened to citizens at town hall meetings explain their circumstances, such as how they became uninsured abruptly and at difficult times. He explained that both legislators and the American public need just one story, a tragic story, to place a face on the millions of uninsured and draw widespread attention to the problem.

He explained that everyone involved in attacking the problem is going to have to make sacrifices to come to a consensus. Not any one group will get what they want, from those advocating single payer to those within the business community advocating only private sector solutions. He would like to see Illinois generate a statewide plan rather than local experiments in insurance expansion. Most of all, Former Senator Simon seeks comprehensive change as soon as possible, reminding us that we have to think big, and that even if it feels like broad goals are unattainable, we must keep these far-reaching goals in mind as we join together to find solutions.

SPEAKERS' BIOGRAPHIES

Larry S. Boress

Larry Boress is Executive Director of the Chicago Business Group on Health (CBGH), a non-profit business coalition. CBGH is a chapter of the Midwest Business Group on Health (MBGH). CBGH is composed of over 70 major, public and private employers having headquarters or employee populations in the Chicago metropolitan area. These firms have an average size of 3,000 employees and provide health benefits to over 1.2 million lives. He also serves as Vice President of the MBGH. CBGH's primary mission is to bring employers together to provide leadership and knowledge to continuously improve the quality and cost-effectiveness of health services provided to employees. Mr. Boress assists member companies in creating purchasing groups, measuring the performance of providers and health plans, sharing of benefit management strategies, and advocating the purchaser's perspective on health care. Prior to joining MBGH in 1991, he spent 17 years at the Illinois State Medical Society. During that time, he assisted physicians in their practices and represented the medical profession in its relationships with hospitals, regulatory agencies, and affiliated professional organizations. Mr. Boress has served as a member of numerous industry and governmental advisory boards, including the Institute of Medicine's Committee to Evaluate Medicare's Professional Review Program, the NCQA's Purchase Advisory Committee and the Chicago Department of Health's Managed Care Advisory Board. In his formal training, he received a Masters in Public Administration from Roosevelt University and a B.A. from Northern Illinois University. Mr. Boress is also a Certified Association Executive.

Madelynne Brown

Madelynne L. Brown has served as Assistant Director of the Illinois Department of Insurance since April 1992. As a regulator she concentrates on consumer market and policy issues. She developed and continues to implement the department's Urban Insurance Initiative, a program that is active in building partnerships between the insurance industry and community groups. Ms. Brown is responsible for health policy issues, including the department's successful implementation of the Health Insurance Portability and Accountability Act. She represents the Director of Insurance as Chair of the Illinois Comprehensive Health Insurance Plan Board. Ms. Brown led the development of the application for and is responsible for the implementation of a $1.2 million federal State Planning Grant to study the uninsured population in Illinois and develop proposals to provide the uninsured with coverage. Her other responsibilities include management of the department's Senior Health Insurance Program and participation in the National Association of Insurance Commissioner activities. Prior to being appointed Assistant Director, Ms. Brown practiced law in Chicago where she concentrated in consumer matters, family issues, and real estate transactions. She has also held marketing management positions at Prudential Insurance Company of America and Control Data Corporation. Assistant Director Brown holds a J.D. with honors from Illinois Institute of Technology, Chicago-Kent College of Law, a master's degree from the America Graduate School of International Management, and a bachelor's degree from Beloit College. She is a Chartered Life Underwriter (CLU).

Lisa Duchon, Ph.D.

Lisa Duchon, Ph.D., is deputy director of The Task Force on the Future of Health Insurance for the Commonwealth Fund, a national philanthropic organization engaged in independent research on health and social policy issues. The mission of the Task Force is to identify and evaluate strategies to expand and improve health insurance coverage for America's workers and working families. She is an author on many Task Force reports released by the Commonwealth Fund, including *Can't Afford to Get Sick: A Reality for Millions of Working Americans* and *Listening to Workers: The Commonwealth Fund 1999 National Survey of Workers' Health.* Prior to joining the Fund in February 1999, Dr. Duchon was Executive Director of Healios Health Network, the first managed long term care company organized as an independent practice association of skilled nursing facilities in the New York City metropolitan area. Before coming to New York, she was Director of Public Affairs for the Denver Department of Health and Hospitals, one of the most comprehensive urban public health systems in the U.S. She began her career in health care as a management engineer for Kaiser Permanente in Denver, Colorado. Dr. Duchon holds a B.S. in Industrial Engineering, from the University of Oklahoma, an M.P.A. from the University of Colorado and a Ph.D. in Public Administration from New York University.

Jim D. Mortimer

Jim Mortimer organized the Midwest Business Group on Health (MBGH) in 1980 with a group of twenty employers who came together from Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, and Wisconsin. Their purpose was to create a vehicle to learn new ways to manage health benefit plan costs. Now in its twentieth year, MBGH has about 100 members and spans an eleven-state region. Its mission is to "provide employer leadership and knowledge to continuously improve the quality and cost-effectiveness of health services." MBGH works with its members to research and develop new tools for health care purchasing and consumer information, and with local chapters to lead health market reforms. Prior to MBGH, Mr. Mortimer worked for fourteen years for the largest bank in Chicago. He held the title of Second Vice President in the personnel division responsible for employee benefits, employee relations, medial services and employee counseling. Mr. Mortimer is a member of many health care organizations and boards. He serves as a director of the National Business Coalition on Health and chairman of its Education and Research Committee, a director of the American Health Quality Association, a member of the Board of Pensions of the Presbyterian Church (USA), and a director of the Chicago Center for Health System Development. He is a member of the Business Advisory Group and other task forces of the Joint Commission on Accreditation of Healthcare Organizations, and a member of the Medicare Task Force of The Century Foundation in New York. Mr. Mortimer is a graduate of the University of Iowa with a degree in psychology. He has taken graduate courses in business and mathematics at Loyola University, Chicago. Currently, Mr. Mortimer is a member of the Illinois Assembly on the Uninsured.

M. Edith Rasell, M.D., Ph.D.

Edith Rasell is an economist at the Economic Policy Institute, a think tank in Washington, D.C. Dr. Rasell's primary areas of research are health care funding, social insurance programs, and labor economics. She has written numerous papers for the Economic Policy Institute and her work has been published in the *American Economic Review* and the *New England Journal of Medicine*, as well as other journals and the popular press. She is also the author of Paycheck Economics, a popular economic education publication for EPI. Dr. Rasell is currently the director of EPI's Economic and Analysis Research Network, a nationwide association of state-based research groups that examine living standards and other issues important to working people. Dr. Rasell has testified before congressional committees on health and workplace issues and has been frequently cited by the news media in major daily newspapers, highly rated radio and television network news, and information programs. She began her career as a physician and following her residency, was board certified in Family Practice. However, her interest in economic issues led her to study in this field and she earned a Ph.D. in economics from American University in Washington, D.C. The Economic Policy Institute is a Washington, D.C. based research organization, founded in 1986 to widen the debate about policies for achieving healthy economic growth, broadly shared prosperity, and opportunity in the U.S. and around the world. The Institute works with a growing network of economists, scholars, and state research groups across the country.

Paul Simon

Paul Simon joined the faculty of Southern Illinois University in 1997, just weeks after retiring from the U.S. Senate. Founder and director of the Public Policy Institute, he teaches classes in legislative process for the Department of Political Science and non-fiction writing for the Department of Journalism. Former Senator Simon attended the University of Oregon and Dana College in Blair, Nebraska. At the age of 19, he became the nation's youngest editor-publisher when he accepted the local Lion's Club challenge to save the Troy Tribune in Troy, Illinois. He was elected to the Illinois House in 1954 and to the Illinois Senate in 1962. During his 14 years in the state legislature, he won the Independent Voters of Illinois' "Best Legislator Award" every session. In 1968 he won election to become the state's lieutenant governor. After narrowly losing the 1972 Democratic gubernatorial primary, former Senator Simon started the public affairs reporting program at Sangamon State University (now the University of Illinois at Springfield) and lectured during the 1972-1973 school year at the John F. Kennedy School of Government at Harvard University. He was elected to the U.S. House of Representatives in 1974 and to the U.S. Senate, upsetting a three-term incumbent in 1984. In 1987-1988, he sought the democratic nomination for president, and in 1990 he won re-election to the Senate with the largest plurality of any contested candidate for senator or governor of either party that year. In the 104th Congress he served on the budget, labor and human resources, judiciary and Indian affairs committees. He has also served on the foreign relations committee. He was the leading Senate champion of the new direct college loan program enacted in 1991, chief Democratic sponsor of the balanced budget amendment, and spearheaded the drive to curb television violence which led to the first joint standards on violence by the broadcast networks, the Parental Advisory System, and the new independent monitoring programs launched by the broadcast and cable networks in 1994. He also wrote the National Literacy Act, the School-To-Work Opportunities Act, the Job Training Partnership Act amendments, several provisions of the Goals 2000 Act, and the 1994 reauthorization of the Elementary and Secondary Education Act. During his years as a lawmaker, former Senator Simon wrote a newspaper column, "P.S./Washington," which ran for more than 45 years. The column was one of the few written by legislators that was not ghost-written by staff, and has been called "political science at its best." Former Senator Simon holds 44 honorary degrees and has written 16 books (three with co-authors). Currently, he serves as Co-chair of the Illinois Assembly on the Uninsured.

Hank S. Webber

Mr. Webber joined the University of Chicago in 1986 and currently serves as Vice-President for Community and Government Affairs and Senior Lecturer in the School of Social Service Administration. His previous positions at the University include Associate Vice-President for Administration and Assistant Vice-President for Human Resources. As the University's Community and Government Affairs Officer, he is responsible for the University's real estate, security, city, state, and federal government relations, public school and community outreach activities. He also directs a set of student affairs units. In addition to his appointment in the School of Social Service Administration, Mr. Webber has taught in the Law School and Harris Graduate School of Public Policy Studies at the University of Chicago. Course offerings include Health Policy, the Financial Management of Health Care Organizations, Managed Care, Negotiation Theory and Practice, and the Structure of Human Service Delivery Systems. He has written widely on hospital financial status, hospital closures, Medicaid policy and health care for the elderly. Mr. Webber is the Chairman of the Board of Directors of Horizons Hospice and the North Kenwood-Oakland Charter School and a Board member of the Fund for Community Redevelopment and Revitalization, the Woodlawn Preservation and Investment Corporation, Court Theatre, KAM Isiah Synagogue, and the Health and Medicine Policy Research Group. Mr. Webber has a B.A. from Brown University and a M.P.P. from the John F. Kennedy School of Government at Harvard University.

Raymond B. Werntz, J.D.

Ray Werntz was named President of the Consumer Health Education Council (CHEC) in May 1999. CHEC's mission is to reduce the number of uninsured and improve the health of the general public through information and research that helps individuals and plan sponsors understand the value and uses of private and public health insurance. CHEC is part of the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF), and like its parent organization, CHEC is a nonpartisan group that does not lobby and does not take positions on specific policy proposals. EBRI-ERF has been conducting objective and widely utilized analysis of health and retirement issues for more than 20 years. Previously, Mr. Werntz was Vice President of Compensation and Benefits for Whitman Corporation in Rolling Meadows, Illinois where he was a strong proponent of health and financial education for employees and their families. In addition to his over thirty years' experience as a human resources executive, Mr. Werntz is a member of the Midwest Business Group on Health Board of Directors and served on the Board of the Washington Business Group on Health and as the first chairman – and later as a business member – of the Illinois Health Care Cost Containment Council (statewide hospital charges' database). He also serves on the Board of the Health and Medicine Policy Research Group and served previously on boards of other Chicago-based private and public sector organizations established to address heath care policy, delivery, quality, education and access for low income Chicago residents. Mr. Werntz, a Chicago native, has a B.A. and M.A. in history and philosophy from DePaul University and a J.D. from John Marshall Law School.

Quentin D. Young, M.D.

Dr. Young is a practicing internist in Hyde Park, a Clinical Professor of Preventive Medicine at the University of Illinois Medical Center and Senior Attending Physician at Michael Reese Hospital. During the 1970s and early 1980s, he served as Chairman of the Department of Internal Medicine at Cook County Hospital, where he helped establish the Department of Occupational Medicine. In addition to his distinguished career as a physician, Dr. Young has been a leader in public health policy and medical and social justice issues. In 1980, Dr. Young founded the Chicago based Health & Medicine Policy Research Group, of which he is currently Chairman. Dr. Young is also the National Coordinator of Physicians for a National Health Program (PNHP), a Chicago based organization of over 6000 physicians who support single-payer national health insurance. He has served as Chairman of the American College of Physicians' Subcommittee on Human Rights and Medical Practice and has been a member of both the Humana-Michael Reese Medical Board and the American College of Physicians Health and Public Policy Committee. In 1997-1998, he served as the President of the American Public Health Association and in 1999 he was inducted as a Master of the American College of Physicians. Dr. Young regularly hosts "Odyssey" on WBEZ, Chicago public radio. Dr. Young has chosen to limit his medical practice in order to spend more time fighting the corporate takeover of medicine in America. Currently, Dr. Young is a member of the Illinois Assembly on the Uninsured.

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